DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES 45th 11/18/16 70th 12/13/16

PRINTED: 10/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445116	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, SMITHVILLE	825 FISHER AVE P O BOX 649 SMITHVILLE, TN 37166

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 10/3/16. During this Life Safety Survey, NHC of Smithville was found not in substancial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2000. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:	K 000	*This plan of correction is submitted as required under State and Federal Law and does not constitute an admission on the part of NHC HealthCare Smithville that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observations and testing during the fire	K 018	K018 Maintenance Supervisor inspected latching devices on doors in Room 206, Room 219, MDS Office, Activities Office, Patient Break Room, and Case Manager Office. All doors latching correctly. Maintenance Supervisor randomly inspected latches on doors throughout the center on 10/11/16. All doors latching correctly. Maintenance Supervisor will conduct a Quality Assurance Study (QA) on door latching. Maintenance supervisor will inspect random doors in the center for proper latching. QA will be conducted weekly for 3 weeks or until substantial compliance. Findings will be reported to the QA Committee on 11/3/16. QA Committee consists of Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Assistant Director of Nursing, and Director of Rehab.	11/3/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. Earl Hall
TITLE: Administrator
(X6) DATE: 10/20/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 drill , the facility failed to maintain the corridor doors. The finding included: Observation and testing during the fire drill on 10/3/16 at 1:30 PM through 1:40 PM, revealed the following corridor doors not fully latched within the frame in the following locations. a. 206 b. 319 c. MPS care office d. Activities e. Partner break f. Casemanager. National Fire Protection Association (NFPA) 101, 19.3.6.3 (2000 Edition) Maintenance staff was present when the deficiencies were identified, and acknowledged by the administrator during the exit conference on 10/3/16.	K 018		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2	K 021	K021 Penetrations in ICF Fire Door and Reflections fire doors were repaired on 10/4/16. Maintenance Supervisor observed all other fire doors for penetrations on 10/4/16. No other penetrations found. Maintenance Supervisor will conduct a Quality Assurance Study (QA) on fire doors for penetrations. QA will be conducted weekly for 3 weeks or until substantial compliance. Findings will be reported to the QA Committee on 11/3/16. QA Committee consists of Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Assistant Director of Nursing, and Director of Rehab.	11/3/2016

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K 021	Continued From page 2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the cross corridor fire doors. The finding included: Observation on 10/3/16 at 8:48 AM, revealed penetrations (holes from removed hardware) on the cross corridor fire doors (1 1/2 hr rated) in the following locations: a. ICF fire doors (2 of 2) b. Reflections fire doors (2 of 2). NFPA 101, 4.6.2.1 (2000 Edition), NFPA 101, 8.2.3.2.1 (2000 Edition) NFPA 80, 15-2.5.4 (1999 Edition) Maintenance staff was present when the deficiencies were identified and acknowledged by the administrator during the exit conference on 10/3/16.	K 021		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with a hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are	K 029		

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K 029	Continued From page 3 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the hazardous areas. The findings included: 1. Observation on 10/3/16 at 10:12 AM, revealed a three (3) inch penetration sprinkler pipe (masonry wall) in the back parking lot boiler room. 2. Observation on 10/3/16 at 10:13 AM, revealed seam on the back wall joining the side wall was not sealed from the floor to deck (masonry wall) in the back parking lot boiler room. 3. Observation on 10/3/16 at 12:59 PM, revealed multiple penetrations in the masonry wall of the ICF boiler room consisting of metal conduit, wires, improper fire stop, and holes. NFPA 101, 19.3.2.1 (2000 Edition) Maintenance staff was present when the deficiencies were identified, and acknowledged by the administrator during the exit conference on 10/3/16.	K 029	K029-Maintenance Supervisor, in consultation with a 3M supervisor and Firestop Technologies, will repair the penetrations and seal the seam in the back parking lot boiler room and repair the penetrations in the ICF boiler room by 11/15/16 Maintenance Supervisor, along with the 3M supervisor, reviewed other hazardous areas of the center (boiler rooms and mechanical rooms) for penetrations on 10/18/16. All areas in compliance. Maintenance Supervisor will conduct a Quality Assurance Study (QA) on penetrations in hazardous areas (boiler rooms and mechanical rooms). QA will be conducted weekly for 3 weeks or until substantial compliance. Findings will be reported to the QA Committee on 11/10/16. QA Committee consists of Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Assistant Director of Nursing, and Director of Rehab	11/15/2016
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observations, the facility failed to	K 052		

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K 052	Continued From page 4 maintain the fire alarm system. The finding inlcuded: Observation on 10/3/16 at 10:05 AM, revealed a cart obstructing a manual fire alarm pull station in the kitchen (removed by maintenance). NFPA 101, 19.3.4.5.1 (2000 Edition), NFPA 101, 9.6.1.7 (2000 Edition), NFPA 72, 2-8.2.1 (1999 Edition). Maintenance staff was present when the deficiency was identified, and acknowledged by the administrator during the exit conference on 10/3/16	K 052	K052-Cart was removed by maintenance supervisor on 10/3/16 Maintenance Supervisor inspected the areas around fire alarm pull stations in 3 other random areas in the center on 10/4/16. All areas found to be in compliance. Maintenance supervisor will inservice staff on not obstructing fire alarm pull stations by 10/26/16 Maintenance Supervisor will conduct a Quality Assurance Study (QA) on 3 random areas around fire alarm pull stations for no obstructions. QA will be conducted weekly for 3 weeks or until substantial compliance. Findings will be reported to the QA Committee on 11/3/16. QA Committee consists of Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Assistant Director of Nursing, and Director of Rehab.	11/3/2016
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the smoke detectors. The finding included: Observation on 10/3/16 at 10:20 AM, revealed a smoke detector within three (3) feet of HVAC air flow in the corridor next to the social service office. NFPA 101, 19.3.4.5.1 (2000 Edition), NFPA 101, 9.6.1.7 (2000 Edition) NFPA 72, 2-3.5.1 (1999 Edition). Maintenance staff was present when the deficiencies were identified, and acknowledged by the administrator during the exit conference on 10/3/16.	K 054	K054-Smoke detector was moved to an area further away from the HVAC air flow by Simplex Grinnell on 10/14/16. Maintenance supervisor inspected 3 other random smoke detectors in the center to ensure they were not within 3 feet of an HVAC air flow on 10/4/16. All areas in compliance Maintenance Supervisor will conduct a Quality Assurance Study (QA) on 3 random smoke detectors to ensure they are not located within 3 feet of HVAC air flow. QA will be conducted weekly for 3 weeks or until substantial compliance. Findings will be reported to the QA Committee on 11/3/16. QA Committee consists of Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Assistant Director of Nursing, and Director of Rehab.	11/3/2016
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062 SS=D	Continued from page 5 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the sprinkler system. The findings included: 1. Observation on 10/3/16 at 9:03 AM, revealed a damaged sprinkler in the ICF clean linen room and in the ICF activity room. NFPA 101, 19.3.5.1 (2000 Edition) NFPA 101, 9.7.11 (2000 Edition) NFPA 13, 12-1 (1999 Edition) NFPA 25, 12-1 (1999 Edition) 2. Observation on 10/3/16 at 9:25 AM, revealed the storage area (behind the ICF boiler room) had no sprinkler coverage. NFPA 101, 19.3.5.1 (2000 Edition) NFPA 101, 9.7.1.1* (2000 Edition) 3. Observation on 10/3/16 at 12:47 PM, revealed sprinkler lines supporting HVAC duct work and other miscellaneous pipes in the following locations: a. Long hall by therapy b. ICF short hall corridor by 203 c. Corridor by ICF activities. NFPA 101, 19.3.5.1 (2000 Edition), NFPA 9.7.1.1* (2000 Edition) NFPA 13, 6-1.1.5* (1999 Edition) Maintenance staff was present when the deficiencies were identified, and acknowledged by the administrator during the exit conference on 10/3/16.	K 062	K062 1) Sprinklers will be replaced in ICF clean linen room and ICF activity room by 11/15/16. 2) Sprinkler coverage will be added to the storage area behind the ICF boiler room by 11/15/16. 3) HVAC duct work and other pipes were secured in the long hall by therapy, the ICF short hall by 204, and the corridor by ICF activities on 10/4/16 to ensure they were not placing any pressure on sprinkler lines. Maintenance supervisor observed random sample of 10 other sprinklers in center on 10/4/16. All sprinklers in compliance. Maintenance supervisor observed random sample of other areas of the center to ensure no objects were resting on or placing pressure on sprinkler lines on 10/4/16. All sprinkler lines not supporting other objects. Maintenance supervisor will conduct a Quality Assurance Study (QA) on sprinklers. QA will be conducted on 10 random sprinklers weekly for 3 weeks or until substantial compliance, to ensure they are not damaged. Findings will be reported to the QA Committee on 11/3/16. QA Committee consists of Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Assistant Director of Nursing, and Director of Rehab.	11/15/2016

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K 066 K 066 SS=D	Continued From page 6 NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, the facility failed to comply with the smoking regulations. The finding included: 1. Observation on 10/3/16 at 9:24 AM, revealed cigarette filters disposed on the landscape mulch around the courtyard area. 2. Observation on 10/3/16 at 9:24 AM, revealed cigarette filters in a trash can (combustible) the courtyard area.	K 066 K 066	K066-Cigarette filters were removed from mulch and trashcan and properly disposed of on 10/4/16. Maintenance supervisor inspected other areas of the center for cigarette filters in mulch or trashcans on 10/4/16. All areas clear of cigarette filters. Facility has a designated smoking area and all cigarette filters were properly disposed. Maintenance supervisor will inservice staff on only smoking in the designated smoking area by 10/26/16. A no smoking sign will also be placed in the courtyard by 10/26/16 Maintenance Supervisor will conduct a Quality Assurance Study (QA) on cigarette filters (smoking) in the courtyard area. QA will be conducted weekly for 3 weeks or until substantial compliance. Findings will be reported to the QA Committee on 11/3/16. QA Committee consists of Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Assistant Director of Nursing, and Director of Rehab.	11/3/2016

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K 066	Continued From page 7 Maintenance staff was present when the deficiencies were identified, and acknowledged by the administrator during the exit conference on 10/3/16.	K 066		
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the requirement of combustible decorations. The finding included: Observation on 10/3/16 at 9:00 AM through 9:30 AM, revealed decorations not treated with flame retardant in the following locations: 102, 104, 105, 207, the ICF activities and the Reflections activities area. NFPA 101, 19.7.5.4 (2000 Edition) Maintenance staff was present when the deficiencies were identified, and acknowledged by the administrator during the exit conference on 10/3/16.	K 073	K073 All combustible decorations in Rooms 102, 104, 105, 207, ICF Activity Room, and Reflections Activity Room will either be treated with NFPA 255 rated fire retardant or removed from the center by 11/1/16 Maintenance supervisor inspected other random areas/rooms of center for combustible decorations on 10/4/16. All decorations in compliance. Maintenance supervisor will inservice staff on combustible decorations by 10/26/16. Maintenance supervisor will conduct a Quality Assurance Study (QA) on combustible decorations. QA will be conducted on random areas/rooms in center weekly for 3 weeks or until substantial compliance. Findings will be reported to the QA Committee on 11/3/16. QA Committee consists of Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Assistant Director of Nursing, and Director of Rehab.	11/3/2016
K 077 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4. This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the piped in medical gas lines. The finding included:	K 077		

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K 077	Continued From page 8 Observation on 10/3/16 at 12:50 PM, revealed dissimilar metals touching medical gas lines above the ceiling in the following locations: a. Skilled (long) hall by therapy b. O2 storage room (12:53 PM) NFPA 101, 19.3.2.4 (2000 Edition) NFPA 99, 4-3.1.2.9 (1999 Edition) Maintenance staff was present when the deficiencies were identified, and were acknowledged by the administrator during the exit conference on 10/3/16.	K 077	K077-Medical gas lines are abandoned and not in use. Administrator letter is included at the end of this plan of correction.	11/1/2016
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protectives shall be as follows: (1) 2-hour fire barrier - 1 1/2-hour fire protection rating (2) 1-hour fire barrier - 1-hour fire protection rating where) used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42 NFPA 101, 8.2.3.2.3.1* (2000 Edition) 8.2.3.2.4 Penetrations and Miscellaneous Openings in Fire	K 130	K130--Reflections fire door was recalibrated and hinges tightened on 10/17/16. Penetrations were repaired in long hall riser room and fire wall by Room 214 on 10/17/16. Maintenance supervisor inspected 3 other random fire doors to ensure ease of opening and closing on 10/12/16. All fire doors working properly. Maintenance supervisor inspected 3 other random areas for penetrations on 10/12/16. No other penetrations found. Maintenance Supervisor will conduct a Quality Assurance Study (QA) on 3 randomly selected fire doors and 3 randomly selected areas for penetrations. QA will be conducted weekly for 3 weeks or until substantial compliance. Findings will be reported to the QA Committee on 11/10/16. QA Committee consists of Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Assistant Director of Nursing, and Director of Rehab	11/10/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 9 Barriers. 8.2.3.2.4.1* Openings in fire barriers for air-handling ductwork or air movement shall be protected in accordance with 9.2.1. 8.2.3.2.4.2* Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) *Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met:	K 130		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445116	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/03/2016

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K 130	Continued From page 10 a. The material shall be capable of maintaining the fire resistance of the fire barrier. b. The material shall be protected by an approved device that is designed for the specific purpose. (4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the fire barrier. b. It shall be made by an approved device that is designed for the specific purpose. NFPA 101, 8.2.3.2.4 (2000 Edition) 7.2.1.4.5 The forces required to fully open any door manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf (133 N) to set the door in motion, and 15 lbf (67 N) to open the door to the minimum required width. Opening forces for interior side-hinged or pivoted-swinging doors without closers shall not exceed 5 lbf (22 N). These forces shall be applied at the latch stile. NFPA 101, 7.2.1.4.5 (2000 Edition) Based on observations and testing the facility failed to comply with the following NFPA Life Safety Code (2000 Edition) requirements. The findings included;	K 130		

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K 130	Continued From page 11 1. Observation and testing of the Reflection cross corridor fire door in the means of egress on 10/3/16 at 11:08 AM, revealed it required more than 15 lbs of force to fully open. NFPA 101, 19.2.1 (2000 Edition) NFPA 101, 7.2.1.4.5 (2000 Edition) 2. Observation on 10/3/16 at 1:47 PM, revealed fire wall penetrations in the following locations: a. Long hall sprinkler riser room (1/2 inch metal conduit Gypsum wall) b. Fire wall by 214 (2 inch hole and 1 inch metal conduit masonry wall) 2:00 PM. NFPA 101, 4.6.1.2 (2000 Edition) and NFPA 101, 8.2.3.2.3.1* (2000 Edition) Maintenance staff was present when the deficiencies were identified, and were acknowledged by the administrator during the exit conference on 10/3/16.	K 130		